

Bureau of Health Care Quality and Compliance

|   |   |  |  |                          |  |
|---|---|--|--|--------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>NVN4942TLF</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/14/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE LAUNCHING PAD, INC</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1465 SBRAGIA WAY<br/>SPARKS, NV 89431</b>                                    |                          |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |  |
| T 000   | <p>Initial Comments</p> <p>This findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>This Statement of Deficiencies was generated as a result of the State Licensure survey conducted at your facility on 10/14/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for five residential program beds for transitional living for released offenders. The census at the time of the survey was zero. No client files were reviewed. The facility appeared empty and there was an auction notice in the yard. The administrator was called and she stated the facility had been closed for months.</p> | T 000  |  |                          |  |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE